Health Professionals Services Program

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FISCAL YEAR 2016 MID-YEAR REPORT

REPORT SUBMITTED TO THE
HEALTH LICENSING BOARDS AND THE
HEALTH PROFESSIONALS SERVICES PROGRAM'S
PROGRAM AND ADVISORY COMMITTEES
BY MONICA FEIDER, MSW, LICSW, PROGRAM MANAGER
AND HPSP STAFF
FEBRUARY 2016

REPORT CONTENT

INTRODUCTION

The Health Professionals Services Program (HPSP) is pleased to provide our mid-year report to the Health Licensing Boards, the HPSP Program Committee and Advisory Committees, legislators and the citizens of Minnesota. The document providers readers with information about program participation and activities that took place in the first half of fiscal year 2016 (July 1, 2015 to December 31, 2015).

MISSION AND GOALS

MISSION

Minnesota's Health Professionals Services Program protects the public by providing monitoring services to regulated health care professionals whose illnesses may impact their ability to practice safely.

GOALS

The HPSP goals are to promote early intervention, diagnosis, and treatment for health professionals with illnesses, and to provide monitoring services as an alternative to board discipline. Early intervention enhances the likelihood of successful treatment, before clinical skills or public safety are compromised.

WHAT PROGRAM PARTICIPANTS SAY

Health practitioners are referred to HPSP for the monitoring of a variety of illnesses including substance, psychiatric and other medical conditions. Many practitioners report great shame, fear and/or anxiety when reporting themselves whereas others look forward to the accountability monitoring offers.

HPSP surveys health practitioners following completion and discharge from the program. Many comments describe the structure monitoring provides is a motivating or accountability measure that helps them in following through with various treatment requirements and maintaining their sobriety. A sampling of these comments are listed below:

- *HPSP kept me accountable. I also knew my license was safe as long as I was following HPSP guidelines.*
- *I really felt it was a supportive program rather than one that was punitive. It helped me get a solid foundation in my recovery by helping plat the seed…that will be a part of my future…*
- *The whole program kept me staying on track to my recovery.*
- *Monitoring with screens gave me a period of accountability that was very helpful.*

In addition to the above, practitioners are increasingly asking for more online services. HPSP will focus on this in the coming years.

PROGRAM PARTICIPATION

DEFINITIONS OF REFERRAL SOURCES

HPSP's intake process is fairly consistent, regardless of how licensees are referred for monitoring. The program is responsible for evaluating the licensee's eligibility for services and whether an illness is present that warrants monitoring. If it is determined that a licensee has an illness that warrants monitoring, a Participation Agreement is developed and monitoring is initiated. Practitioners can be referred to HPSP in the following ways:

1. **Self-Referrals:** Licensees refer themselves directly to the program.
2. **Third-Party Referrals:** The most common referrals from third parties are from employers and treatment providers. The identity of all third party reporters is confidential.
3. **Board Referrals:** Participating boards have three options for referring licensees to HPSP:
    a. **Determine Eligibility** (Board Voluntary): The boards refer because there appears to be an illness to be monitored but a diagnosis is not known.
    b. **Follow-up to Diagnosis and Treatment** (Board Voluntary): The board has determined that the licensee has an illness and refers the licensee to HPSP for monitoring of the illness.
    c. **Action** (Board Discipline): The board has determined that there is an illness to monitor and refers the licensee to HPSP as part of a disciplinary measure (i.e.: Stipulation and Order). The Board Order may dictate monitoring requirements.

TRUE SELF-REFERRALS

HPSP measures four types of referrals to the program: self-referrals, third party referrals, informal board referrals (voluntary), and formal board referrals (disciplinary). The category of self-referral has been questioned as to whether we are measuring "true" self-referrals, because some of the self-referred participants seem to have been coerced into reporting to HPSP – whether by a treatment provider, an employer, or a family member. HPSP has received requests to tease out which self-referrals are "true," that is, absent coercion or external motivation. We believe it is not necessary to tease out this information. It is neither easily determined nor relevant to HPSP goals. Problematically, there is no motivational scale to measure whether a self-referral was due to greater internal motivation versus greater external motivation.

In the case of a substance disordered practitioner, questioning the practitioner's motivation for treatment and sobriety assumes a moral component and denies the science of addiction, which is focused on altered brain plasticity. A practitioner whose addiction is severe usually does not have sufficient insight to arrest his or her own disease process alone. There is emerging science showing how the disease of addiction affects the brain. Dr. Nora Volkow of the National Institute on Drug Addiction has coined the following descriptor: "Addiction hijacks the brain." Alcohol and other addictive substances change the structure of the brain which, in turn, affects one's thoughts and behaviors. Brain research suggests that active substance abuse results in a diminished capacity to incorporate new learning and information into memory. Due to this limited consciousness of the destructive consequences, the addict typically comes into treatment only by way of external causes (spouse's threat, job problems, license discipline, legal difficulties) and rarely because of insight into their behavior.

It is not reasonable to expect one to think logically about the consequences of one's alcohol and drug use when their brain circuitry is impaired.

In contrast to substance use disorders, the average person is less judgmental with other health disorders. We don't assume a practitioner "chose" to be ill or question what motivated them to seek treatment. However, anecdotally these practitioners are <u>as likely</u> to need external motivation to self-refer to HPSP. While substance use disordered practitioners suffer from the phenomenon of denial of the severity of their illness, practitioners with other disorders may feel their illness was thrust upon them and that monitoring is another part of the victimization associated with their illness.

HPSP does collect data as to how the participant learned about the program. This is more helpful to us as we conduct our outreach efforts. We strive for early intervention into illnesses. We assist with educating that particular illnesses can progress to the point of causing patient harm.

Many practitioners first learn about HPSP from their employers or treatment providers. From the employer and treatment provider point of view, our experience is they nearly always prefer that the practitioner self-refer over making a third party referral. Is this coercion? Or is it encouragement with a goal toward insight on the part of the practitioner? We have seen treatment providers "encourage" self-referrals as part of the treatment goal toward developing insight into the illness. We have seen this proved out with substance disordered participants, when after a period of time in HPSP (usually about the time their brain chemistry normalizes) they may express gratitude for the structure of HPSP and how it assisted them in their recovery.

So who are the true self-referrals? They all are. The amount of internal or external motivation is irrelevant. One may self-refer because their employer demands, or because there psychiatrist encourages them to refer, or to avoid reporting the illness to their regulatory board, or because they recognize that the substance use problem has put their health, relationships, and career at risk.

ACTIVE CASES

A total of 535 health professionals were active with HPSP on January 4, 2016. The term *active* refers to persons in the intake process as well as those being monitored. The table below provides the number and percent of active cases by Board on January 4, 2016.

Board	Number	Percent
Behavioral Health and Therapy	19	3.55%
Nursing Home Administrators	1	0.19%
Chiropractic Examiners	8	1.50%
Dentistry	32	5.98%
Department of Health	8	1.50%
Dietetics and Nutrition	3	0.56%
EMS	17	3.18%
Marriage and Family Therapy	3	0.56%
Medical Practice	88	16.45%
Nursing	288	53.83%
Pharmacy	24	4.49%
Physical Therapy	12	2.24%
Podiatric Medicine	1	0.19%
Psychology	6	1.12%
Social Work	18	3.36%
Veterinary Medicine	7	1.31%
Sum	**535**	

First Referral Sources for Active Cases

It is not uncommon for health professionals to be referred to HPSP by more than one source. *The first referral source* refers to how HPSP initially learned about the practitioner during this enrollment. This should not be confused with practitioners who were referred and discharged and later referred again (these are two separate cases for the same practitioner). For example, we often see self-referrals followed almost immediately by third party referrals or vis-a-versa.   Whichever referral came first is considered the *first referral source*.

The first referral sources for the 535 active HPSP cases on January 4, 2016 were as follows:

- Self: 267 (50%)
- Board voluntary: 120 (22%)
- Board discipline: 91 (17%)
- Third party: 57 (11%)

REFERRALS BY FIRST REFERRAL SOURCE

HPSP received a total of 216 referrals in the first half of fiscal year 2016. These referrals represent the number of cases opened during the first half of the fiscal year. The referrals represent practitioners new to HPSP or who returned to HPSP. The chart on the right shows the number and percent of referrals by first referral source.

Third Party, 32, 15%
Board Voluntary, 78, 36%
Self, 82, 38%
Board Discipline, 24, 11%
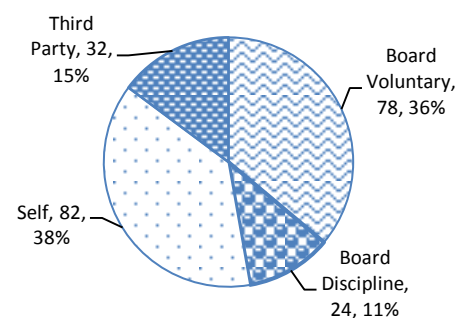
REFERRALS BY FIRST REFERRAL SOURCE AND BOARD

The table below compares the number of licensees referred to HPSP in the first halves of fiscal years 2015 and 2016:

Referral Source	Nursing Home Admin.		Behavioral Health & Therapy		Chiropractic Examiners		Dentistry		Department of Health		Dietetics & Nutrition		Emergency Services		Marriage & Family Therapy		Medical Practice	
Fiscal Year	15	16	15	16	15	16	15	16	15	16	15	16	15	16	15	16	15	16
Board Voluntary	0	0	4	3	9	4	45	35	2	3	0	0	0	3	0	1	7	4
Board Discipline	0	0	1	0	0	0	0	1	0	0	0	0	1	1	0	0	4	1
Self	0	0	4	7	2	0	7	0	0	2	0	2	3	1	0	2	11	11
Third Party	0	0	1	0	0	1	4	1	0	0	0	0	0	0	0	0	8	4
Sum	0	0	10	10	11	5	56	37	2	5	0	2	4	5	0	3	30	20

Referral Source	Nursing		Optometry		Pharmacy		Physical Therapy		Podiatric Medicine		Psychology		Social Work		Veterinary Medicine		Sum	
Fiscal Year	15	16	15	16	15	16	15	16	15	16	15	16	15	16	15	16	15	16
Board Voluntary	13	19	0	0	4	1	7	2	0	0	0	0	2	3	1	0	94	78
Board Discipline	26	18	0	0	1	0	0	0	0	1	1	0	0	0	1	2	35	24
Self	48	49	0	0	1	3	2	0	0	0	2	0	4	4	1	1	86	82
Third Party	29	24	0	0	0	1	0	0	0	0	1	0	0	1	0	0	43	32
Sum	116	110	0	0	6	5	9	2	0	1	4	0	6	8	3	3	258	216

REFERRALS BY FIRST REFERRAL SOURCE AND FISCAL YEAR

The chart below shows the number of referrals by first referral source in the first half of the past ten fiscal years.
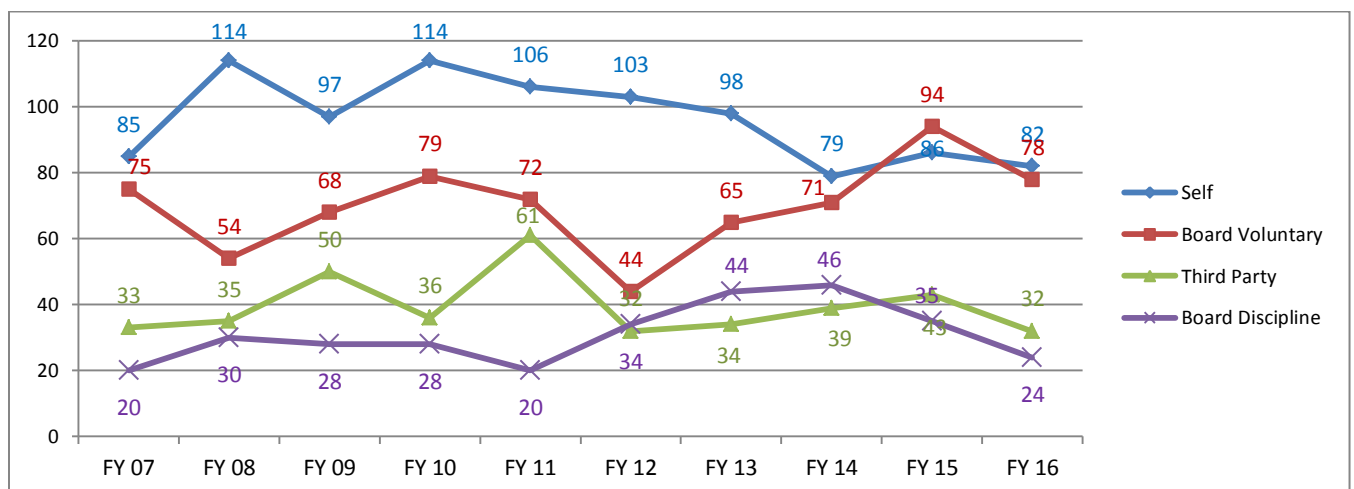
DEFINITIONS OF DISCHARGE CATEGORIES

1. **Completion**

   Program completion occurs when the licensee satisfactorily completes the terms of the Participation Agreement and Monitoring Plan.

2. **Non-Compliance***

   Participant violates the conditions of his or her Participation Agreement/Monitoring Plan; case manager closes case and files a report with licensee's board. Sub-categories of this include:
   - Non-Compliance – Diversion
   - Non-Compliance – Monitoring
   - Non-Compliance – Positive Screen
   - Non-Compliance – Problem Screens
   - Non-Compliance – Treatment

3. **Voluntary Withdrawal***

   Participant chooses to withdraw from monitoring prior to completion of the Participation Agreement and Monitoring Plan; case manager closes case and files a report with the licensee's board.

4. **Ineligible Monitored***

   During the course of monitoring, it is determined that licensee is not eligible for program services as listed in statute; case manager files report with licensee's board. Sub-categories of this include:
   - Ineligible Monitored – Illness too severe
   - Ineligible Monitored – License suspended/revoked
   - Ineligible Monitored – License went inactive
   - Ineligible Monitored – Gave up license
   - Ineligible Monitored – Violation of practice act

5. **Ineligible Not Monitored***

   At time of intake, it is determined that licensee is not eligible for program services as listed in statute; case manager files report with licensee's board. Subcategories of this include:
   - Ineligible Not Monitored – Illness too severe
   - Ineligible Not Monitored – License suspended/revoked
   - Ineligible Not Monitored – License went inactive
   - Ineligible Not Monitored – No active Minnesota license
   - Ineligible Not Monitored – Violation of practice act
   - Ineligible Not Monitored – Previously discharged to the board

6. **No Contact***

   Initial report received by third party or board; licensee fails to contact HPSP; case manager closes case and files a report with licensee's board.

7. **Non-Cooperation***

   Licensee cooperates initially, may sign Enrollment Form and/or releases, but then ceases to cooperate before the Participation Agreement is signed; case manager closes case and files a report with licensee's board.

8. **Non-Jurisdictional**

   No diagnostic eligibility established; the case is closed.

   *Discharge results in report to board and providing data.

REFERRAL AND DISCHARGE TRENDS

The chart below shows the number of referrals and discharges in the first half of each fiscal year since 2007. You will see that the number of referrals and discharges in the first half of fiscal year 2016 were considerably lower than those of the prior two fiscal years. By the end of fiscal year 2016, we will have a better idea if this trend downward will continue.
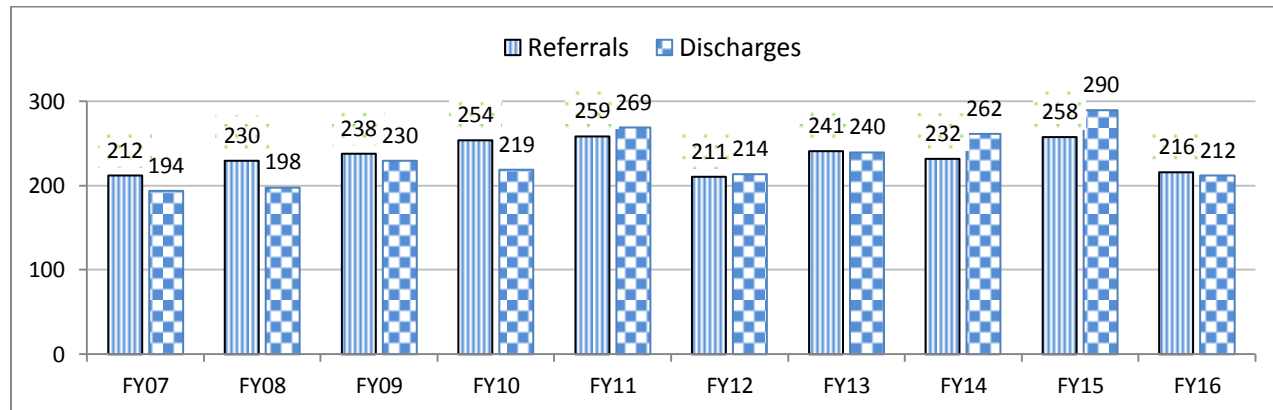
DISCHARGES BY DISCHARGE CATEGORY

A total of 212 health professionals were discharged from HPSP in the first half of fiscal year 2016, compared to 290 in 2015. Of those discharged in the first half of fiscal year 2016, a little more than half, 61%, participated in monitoring. Of those monitored, 55% completed the conditions of their Monitoring Plans.

Discharge Category	Number
Monitored	129
Completion	71
Voluntary Withdraw*	10
Non-Compliance*	28
Deceased	2
Ineligible-Monitored*	18

Discharge Category	Number
Not Monitored	83
Ineligible-Not Monitored*	3
No Contact*	11
Non-Cooperation*	18
Non-Jurisdictional	51
Sum Monitored & Not Monitored	212

Represents discharges that resulted in reports to boards

DISCHARGES BY DISCHARGE CATEGORY AND BOARD

The following table compares the number of licensees discharged from HPSP in the first half of fiscal years 2015 and 2016 by Board.

| Discharge Category	Nursing Home Admin.		Behavioral Health & Therapy		Chiropractic Examiners		Dentistry		Department of Health		Dietetics & Nutrition		Emergency Services		Marriage & Family Therapy		Medical Practice	
Fiscal Year	15	16	15	16	15	16	15	16	15	16	15	16	15	16	15	16	15	16
Completion	0	0	0	0	2	1	2	2	0	0	0	0	2	3	2	0	28	13
Voluntary Withdraw*	0	0	0	0	0	0	1	0	1	0	0	0	1	0	0	0	0	1
Non-Compliance*	0	0	3	2	0	1	2	2	0	0	0	0	1	1	0	0	0	0
Deceased	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Ineligible-Monitored*	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	3	1
Ineligible-Not Monitored*	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	1
No Contact*	0	0	1	0	0	0	4	2	1	0	0	0	0	0	0	0	2	2
Non-Cooperation*	0	0	2	2	0	0	5	1	0	0	0	0	3	0	0	1	2	0
Non-Jurisdictional	0	0	1	0	5	5	31	27	1	1	0	1	3	1	0	1	7	2
Sum	0	0	8	5	7	7	47	35	3	1	0	1	10	6	2	2	42	21

Discharge Category	Nursing		Optometry		Pharmacy		Physical Therapy		Podiatric Medicine		Psychology		Social Work		Veterinary Medicine		Sum	
Fiscal Year	15	16	15	16	15	16	15	16	15	0	15	16	15	16	15	16	15	16
Completion	44	47	0	0	5	0	3	0	0	0	1	2	1	2	0	1	90	71
Voluntary Withdraw*	7	6	0	0	0	0	0	0	0	0	0	1	0	2	0	0	10	10
Non-Compliance*	33	19	0	0	1	3	1	0	0	0	1	0	1	0	0	0	43	28
Deceased	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	2	2
Ineligible-Monitored*	11	13	1	0	0	0	0	0	0	0	0	0	0	2	0	0	15	18
Ineligible-Not Monitored*	10	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	12	3
No Contact*	5	7	0	0	2	0	0	0	0	0	0	0	0	0	0	0	15	11
Non-Cooperation*	16	12	0	0	1	2	1	0	0	0	0	0	0	0	1	0	31	18
Non-Jurisdictional	14	11	0	0	1	0	4	2	0	0	1	0	4	0	0	0	72	51
Sum	140	115	1	0	11	6	9	2	0	0	3	3	6	7	1	1	290	212

Represents discharges that result in a report to the licensing Board.

DISCHARGES OF THOSE MONITORED

The table on the right represents the percent of practitioners that engaged in monitoring in the first half of fiscal year 2016 and were discharged by discharge category.
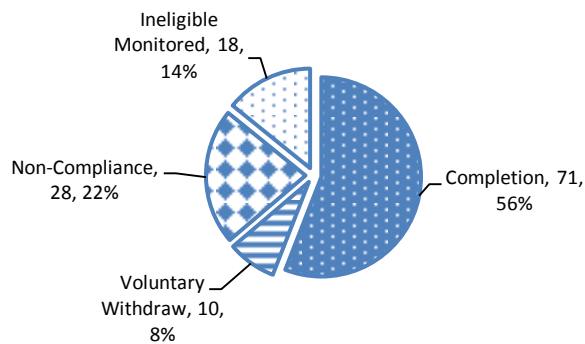
UNSATISFACTORY DISCHARGE DETAIL

The following table shows detailed information about practitioners who, in the first half of fiscal year 2016, engaged in monitoring and were discharged due to non-compliance or being ineligible for continued participation:

Discharge Category	Number
Non-Compliance with Monitoring Plan*	10
Non-Compliance - Problem Screens	7
Non-Compliance - Positive Screen	10
Ineligible Monitored - License Suspended/Revoked/Inactive	15
Ineligible Monitored - Illness Too Severe	2
Ineligible Monitored - Violation of Practice Act	1
Total Number Monitored & Discharged	45

*The discharge category of *Non-compliance with Monitoring Plan* includes persons who refuse to sign authorizations, are non-compliant with treatment or who have used substances of abuse. We hope to further separate the various for discharge in our database and, therefore, in future reports.

DISCHARGES BY REFERRAL SOURCE

The following table shows the number of practitioners discharged from HPSP in the first half of fiscal year 2016 by their first referral source and discharge category:

Discharge Category	Referral Source			
	Board Voluntary	Board Action	Self	Third Party
Completion	15	15	35	6
Voluntary Withdraw	0	1	6	3
Non-Compliance	3	8	14	3
Deceased	1	0	1	0
Ineligible-Monitored	1	6	6	5
Ineligible-Not Monitored	1	1	0	1
No Contact	4	1	0	6
Non-Cooperation	8	1	3	6
Non-Jurisdictional	41	0	7	3

COMMUNICATING UNSATISFACTORY DISCHARGES TO THE BOARDS

The discharge categories described earlier in this document shows that HPSP reports and discharges practitioners to their Boards for multiple reasons. The following flow chart shows how HPSP responds to non-cooperation or non-compliance at different times throughout the intake or monitoring process

Referral to HPSP
- Board Disciplinary
- Board Voluntary
- Self
- Third Party

↓

Licensee contacts HPSP ———— NO ————————————————

YES

↓

Intake performed:
- Program described
- Tennessen provided & eligibility reviewed
- Obtains brief social, vocational, substance and psychiatric histories
- Send enrollment materials
- Gather records
- May request assessments, treatment…
- May ask licensee to refrain from practice

———— NO ————————————————

↓

Licensee cooperates with intake process (i.e. signs authorizations, obtains requested assessments) ———— NO ————————————————

↓

HPSP determines if licensee has an illness that warrants monitoring ———— NO ————→ If no illness identified to monitor, HPDP discharges as non-jurisdictional unless a practice issue is identified, in which case, the practice issue is reported to the Board.

YES

↓

Participation Agreement and Monitoring Plan are developed and licensee signs Participation Agreement ———— NO ————————————————

YES

↓

Licensee complies with conditions of Participation Agreement and Monitoring Plan ———— NO ————→ HPSP reports and **may discharge** the licensee to the Board, depending on the level of non-compliance. Cases are reviewed in team and may be reviewed with Board staff. When filing a report with the Board, HPSP sends a full copy of the HPSP file, with the exception of confidential third party reports. If the third party reporter signs an authorization to allow HPSP to share an un-redacted report with the Board, HPSP forwards it to the Board.

YES

↓

YES = Successful Completion - Board is notified if Board is source of referral

DISCHARGE
HPSP discharges licensee to their Board & provides Board with a copy of file.

10

UPDATES

STRATEGIC PLANNING

Background

HPSP staff identified the need for comprehensive strategic planning. HPSP contracted with Management, Analysis and Development (MAD), which is part of the Department of Management and Budget, to facilitate the initial phases of the process. MAD conducted situational analyses of the Program Committee, Advisory Committee, Executive Directors, HPSP staff, and the HPSP Program Manager. A Strategic Planning team was established consisting of four health licensing board executive directors and HPSP staff. A three to five year vision was created for the program along with one to two year strategies. HPSP staff was then assigned to lead the following strategic goals:

1. Measure program effectiveness, led by Mary Olympia
2. Best practices drive the program, led by Monica Feider
3. Develop governance that supports the program, led by Monica Feider
4. Strengthen Board and HPSP staff relationship and understanding of roles, led by Tracy Erfourth
5. Develop, strengthen and maintain efficient processes, led by Marilyn Miller
6. Promote staff well-being and professional growth, led by Kurt Roberts
7. Enhance program outreach, led by Kimberly Zillmer

HPSP staff developed Strategic Plan Work Groups consisting of HPSP staff, board executive directors and staff as well as members of the Program and Advisory Committees. Action plans were developed to create concrete plans to address each strategy. MAD facilitated the initial sessions of the work groups.

Status

Work on all of the above noted strategic goals is underway. Some of the strategies are time-limited, while others will be ongoing. A full report on the work done to address the strategic goals can be found in the *Strategies and Priorities Update 3* document, which will be provided to the Program Committee and the Executive Directors of the health licensing boards. It is also available upon request.

BUDGET

HPSP's fiscal year 2016 budget is $850,000. In the first half of the fiscal year, HPSP spending was within expected levels. As of December 24, 2015, HPSP spent 42% ($354,749.40) the fiscal year 2016 budget. Primary expenses include:

- Salaries and benefits: $327,306.67
- Rent: $18,195.16

COMMITTEE MEMBERS AND STAFF

PROGRAM COMMITTEE MEMBERS

The Program Committee consists of one member from each health licensing board. By law, the Program Committee provides HPSP with guidance to ensure the direction of HPSP is in accord with its statutory authority. In 1997 the Program Committee established the following five goals to meet this responsibility:

1. The public is protected;
2. Individual clients are treated with respect;
3. The program is well-managed;
4. The program is financially secure; and
5. The program is operating consistent with its statute.

Member Name	Board
Bridgett Anderson	Dentistry
Angelina Barnes (was Brian Stawartz through 11/15)	Psychology
Jennifer Deschaine	Emergency Medical Services
Michelle Falk	Optometry
Kathryn Graves	Marriage and Family Therapy
Yvonne Hundshamer	Behavioral Health and Therapy
Rosemary Kassekert	Social Work
Anne Kukowski (Alt. Catherine Lloyd)	Department of Health
Christine Norton (Alt: Steven Strand)	Nursing
Kathy Polhamus, Vice Chair	Physical Therapy
Allen Rasmussen, Chair (was Mark Eggen, MD through 12/15)	Medical Practice
Nestor Riano (was Greg Steele through 12/15)	Chiropractic Examiners
Margaret Schreiner	Dietetics and Nutritionists
Randy Snyder	Nursing Home Administrators
Judy Swanhom	Podiatric Medicine
Stuart Williams (Alt: Kay Hanson)	Pharmacy
Julia Wilson (was Sharon Todoroff through 12/15)	Veterinary Medicine

ADMINISTERING BOARD

The HPSP Administering Board changed from the Board of Dentistry to the Board of Physical Therapy under the leadership of Marshall Shragg, Executive Director in Fiscal Year 2016.

ADVISORY COMMITTEE MEMBERS

The Advisory Committee consists of one person appointed by various health-related professional associations and two public members appointed by the Governor. The Advisory Committee established the following goals:

1. Promote early intervention, diagnosis, treatment and monitoring for potentially impaired health professionals;
2. Provide expertise to HPSP staff and Program Committee; and
3. Act as a liaison with membership.

Member Name	Association
Sadiq Abdirahman	Public Member
Jim Alexander	MN Pharmacists Assoc.
S. Bruce Benson	MN Health Systems Pharmacists
Lois Bosch	MN Assoc. of Social Workers
Marcia Brower	MN Veterinary Assoc.
Lois Cochrane-Schlutter	MN Psychological Assoc.
Stephen Gulbrandsen (Chair)	MN Dental Assoc.
Jody Haggy (Mathew Keller alt)	MN Nurses Assoc.
Eric Hansen	MN Assoc. of Marriage &Fam. Therapy
Megan Hartigan (Debbie Gillquist alt)	MN Ambulance Assoc.
Richard Hueffmeier	MN Chiropractic Assoc.
Tracy Keizer	MN Academy of Physician Assist.
Teresa Knoedler	MN Medical Assoc.
Sheryl Lundquist	MN Academy of Nutrition and Dietetics
Marie Manthey	MN Nurse Peer Support Network
Jeff Morgan	Physicians Serving Physicians
Rose Nelson	Ad Hoc Member
Karen Sames (Vice-Chair)	MN Occupational Therapy Assoc.
Joseph Twitchell (Tonjia Reed alt)	MN Org. of Registered Nurses
Lisa Weed	MN LPNA/AFSCME

HPSP STAFF

Monica Feider	Program Manager
Tracy Erfourth	Case Manager
Marilyn Miller	Case Manager
Mary Olympia	Case Manager
Kurt Roberts	Case Manager
Kimberly Zillmer	Case Manager
Daisy Chavez	Case Management Assistant
Sheryl Jones	Office Manager

Questions about the content of this report should be directed to Monica Feider at 612-317-3060.